ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
9535 E. DOUBLETREE RANCH ROAD, SUITE 100, SCOTTSDALE, AZ 85258
PHONE (602) 364-1 PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Aug 1, 2017 Case Number: 18-06

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: John Heller DVM
Premise Name: Homeward Bound Veterinary Services
Premise Address: _____
City: Tucson State: Arizona Zip Code: _____
Telephone: (520) 6608-1238

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Randy & Gianna Garry
Address: [redacted]
City: [redacted] State: [redacted] Zip Code [redacted]
Home Telephone [redacted] Randy Cell Telephone: [redacted] Gianna

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

RECEIVED
AUG 1 2017
BY:

C. **PATIENT INFORMATION (1):**

Name: San Francisco "Cisco"

Breed/Species: Pug

Age: 2 years Sex: Male Color: Black

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

John Heller DVM

E. **WITNESS INFORMATION:**

Please provide the name
direct knowledge regard

Jama Duncan

Ed Duncan

Jama, my mother, said she will not lie about the events if questioned. I am not sure about Ed, my father, as they are upset with us for reporting their "friend".

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: Qianna L Garrey

Date: 7/29/17

F. ALLEGATIONS and/or CONCERNS:

On July 19, 2017, John Heller DVM of Homeward Bound Veterinary Services, performed surgery on my parents 2 year old male pug, San Francisco aka "Cisco", to neuter him and remove his hind dew claws. "Cisco" died from this surgery. There are several concerns we have about how this tragedy unfolded and we would like to prevent anything like this from happening to another innocent animal.

I rescued "Cisco" from a home on the Southside of Tucson where he lived his life outside in the elements. His yard mate, another pug, had just recently died during the 115+ degree heat wave. The owner realized that this was no way for a pug to live, and contacted me to rehome him and I placed him with my parents to live out his life as a pampered house pet.

My parents met Dr. Heller several years ago at a shot clinic, at Post Feeds in Marana. They have used his mobile services to euthanize several of their old dogs, closer together than any heart can handle. Through this they became friends, not just professional.

On June 16th, I placed "Cisco" with them, my father made a phone call right then to Dr Heller to have him neutered. He was told he would get him scheduled as soon as possible, and my father was under the impression that he had an agreement with a veterinary office to use their facility. After not hearing from Dr Heller for a while, he called again to schedule a surgery date, and Dr. Heller told them he could come to their HOUSE to do the surgery. Trusting the Vet they agreed. On July 19, my mother called very upset, to inform me what had happened. That Dr Heller had just performed surgery on this 2 year old PUG, in my parents house. He did not have an assistant present, only my parents (78 & 79 years old). He sedated the dog to neuter him and remove both his rear dew claws. He completed the neuter portion of the surgery and the first dew claw when the dog started to move and twitch. I do not know if more medication was administered at this time, I am assuming it was in order for him to complete the surgery. After he removed the last dew claw, "Cisco" had stopped breathing and his heart had stopped. He administered some medications, apparently to counteract the sedative, and started CPR. He put shots of medication directly into his heart but was unable to revive him. He died right there in their house, in my fathers arms! This is unacceptable.

I went to Dr Heller's website, **hwbvet.com** and the services he lists to take care of your pet are:

- Exams and Consultations
- Nutritional Counseling
- Vaccinations
- Microchipping
- Preventative Medicine
- Diagnostics
- Pharmacy

There is no mention of any surgical services, or spay or neuter services. My sister in law who volunteers at Pima Animal Care and Control Center (PACC) called Dr Heller about having a dog

neutered, after this tragedy happened, and she was told that they "do not offer those services and you would have to go to a clinic to have that done". Which makes us question, if they do not offer these services, why was this operation performed by this vet? And WHY was it performed in the clients house without trained assistants and necessary equipment present? I feel this is a breech of duty. I don't understand what lead him to attempt this surgery, much less under the less than ideal conditions he chose to do it under. This was a PUG, with a squished face and natural genetic conditions which in itself may present a higher risk than normal. Did he not identify the potential of increased risks? Why did he not refer them to a clinic? The dog began to move and twitch before the surgery was complete, was this due to his lack of familiarization with the time needed to do the surgery? Or the lack of knowledge of proper medication dosages?

This was a needless death and we would like to prevent this from happening again, how many field surgeries is he actually doing? Please review this case and let us know if this is acceptable practice. I understand surgery is risky and there is always a chance something can go wrong, but when it is done in someones home, by a vet who doesn't perform surgery routinely, without trained assistance, without proper monitoring equipment, on a small brachycephalic dog it greatly increases the risk and makes me question the decision making process of the vet.

Homeward Bound Veterinary Services

6999 W. Sauceda Dr. Tucson, Az. 85743 (520) 668-1238

July 10, 2017
Arizona State Veterinary Medical Examining Board
9535 Doubletree Ranch Road, Ste 100
Scottsdale, AZ 85258
Re case 18-06

I have known Mr. Duncan and his dogs for several years and have spoken to him multiple times over that period, both in advice on his dogs and in social contexts.

After loss of a dog he adopted San Francisco and brought him for vaccines to a vaccine clinic. HE expressed that he wanted him neutered and wished to do at home, as he had had prior house-call veterinarians perform this on prior dogs. He advised he knew the risk, but trusted it would be successful and did ake comment that financial consideration was a small part of decision.

At the time of the adverse event resulting in unexpected death, Mr. Duncan was upset as expected, however made no blame and advised that he did not harbor feelings of blame or ill will.

After contact from a family member, he and his wife advised me of family difficulties in the past.

John Heller, DVM

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: AM Investigative Committee: Alex Casuccio, D.V.M. - Chair
Ryan Ainsworth, D.V.M.
Christine Butkiewicz, D.V.M.
Mary Williams
Ed Hunter, R.Ph

STAFF PRESENT: Tracy Riendeau, CVT – Investigations
Victoria Whitmore, Executive Director
Sunita Krishna, Assistant Attorney General

RE: Case: 18-06
Complainant(s): Randy and Gianna Garry
Respondent(s): John Heller, D.V.M. (License: 3610)

SUMMARY:
Complaint Received at Board Office: 8/1/17
Committee Discussion: 11/7/17
Board IIR: 12/13/17

APPLICABLE STATUTES AND RULES:
Laws as Amended July 2014 (Salmon); Rules as Revised September 2013 (Yellow).

On July 20, 2017, Respondent neutered "Cisco," a 2-year-old male Pug at the pet owner's home. During the procedure, the dog arrested and passed away.

Complainant contends Respondent was negligent in the care of the dog.

Complainant was noticed and was available telephonically.
Respondent was noticed and was present telephonically. Counsel, David Stoll, was present.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Randy and Gianna Gary*
- Respondent(s) narrative/medical record: *John Heller*
- Witness(es) narrative: *Ed and Jama Duncan*

PROPOSED 'FINDINGS of FACT':

1. Respondent holds a mobile unit premise license. When he applied he did not indicate on the application, as required, that he would be performing surgeries; when there is a major change in the scope of veterinary services offered, premises are subject to re-inspection.

2. On July 20, 2017, the pet owner, Ed Duncan, requested Respondent neuter his newly adopted dog. Respondent went to the pet owner's home to perform the neuter. Upon exam, the dog had a weight = 20 pounds, a temperature = 102.2 degrees, a heart rate = 130bpm, and a respiration rate = 20bpm; all systems were normal.

3. The dog was sedated with 0.15mLs dexmedetomidine, 2mgs butorphanol and 15mgs ketamine IM. The dog was not intubated and oxygen was not available. The dog was prepped and a closed castration was performed with 3 – 0 monoment circumferential and transfixing ligatures to each cord; subcutaneous and subcuticular closed with 3 – 0 monoment.

4. Rear dewclaws were also requested to be removed by the pet owner. They were excised with #15 blade, ligatures made with 3-0 monoment and skin was closed with 3-0 monoment.

5. During removal of the second dewclaw, Respondent noticed respiratory arrest and began CPR. He administered 0.5mLs of atipamezole IM to reverse the dexmedetomidine and 1mL epinephrine IC. Epinephrine was repeated without success and the dog passed away.

6. No surgical monitoring was noted.

COMMITTEE DISCUSSION:

The Committee discussed that there were multiple concerns surrounding this case; premise application issues, surgical monitoring, not discussing possible risks to the pet owner and not intubating a brachycephalic dog.

The Committee discussed the difference between sedated and general anesthesia with respect to needing surgical monitoring. They felt that the drug dosages administered to the dog would be considered general anesthesia; the fact that the dog could not swallow, had a loss of a swallow reflex, and could not breathe.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that possible violations of the *Veterinary Practice Act* occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board find:

ARS § 32-2272 (B)(3) performing surgery without indicating on his premise license application that he would be providing such services.

ARS § 32-2272 (C) performing surgery through his premises without advising the Board that there were changes in the scope of veterinary services that were being offered.

ARS § 32-2232 (11) Gross negligence for performing surgery on a brachycephalic breed without an endotracheal tube and oxygen.

ARS § 32-2232 (12) as it relates to AAC R3-11-501 (1) failure to provide current professional and scientific knowledge by performing surgery on a brachycephalic breed without an endotracheal tube and oxygen.

ARS § 32-2232 (18) as it relates to AAC R3-11-702; failure to have oxygen available for surgical procedures.

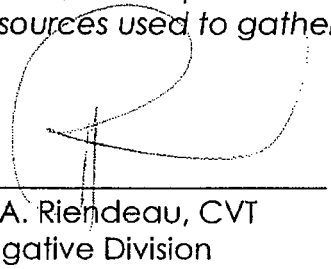
ARS § 32-2232 (18) as it relates to AAC R3-11-704 (3) failure to have an oxygen tank for animals that will receive general anesthesia.

ARS § 32-2232 (21) as it relates to AAC R3-11-502 (H) (1) failure to obtain signed authorization, a verbal authorization that is witnessed by one other individual and documented in the medical record, prior to general anesthesia or surgery is performed.

ARS § 32-2232 (21) as it relates to AAC R3-11-502 (H) (3) failure to record the animal's heart rate and respiratory rate immediately after giving a general anesthetic and monitored and recorded every 15 minutes while anesthesia is being administered.

Vote: The motion was approved with a vote of 4 to 1, with Dr. Butkiewicz abstained.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.



Tracy A. Riendeau, CVT
Investigative Division

DOUGLAS. A DUCEY
GOVERNOR

VICTORIA WHITMORE
EXECUTIVE DIRECTOR

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IN ACCORDANCE WITH § A.R.S. 32-2237(D): "IF THE BOARD REJECTS ANY RECOMMENDATION CONTAINED IN A REPORT OF THE INVESTIGATIVE COMMITTEE, IT SHALL DOCUMENT THE REASONS FOR ITS DECISION IN WRITING."

At the February 21, 2018 meeting of the Arizona State Veterinary Medical Examining Board, the Board conducted an Informal Interview in case 18-06, In Re: John Heller, DVM.

The Board considered the Investigative Committee Findings of Fact, Conclusions of Law, and Recommended Disposition:

1. *ARS § 32-2272 (B)(3) performing surgery without indicating on his premise license application that he would be providing such services.*

2. *ARS § 32-2272 (C) performing surgery through his premises without advising the Board that there were changes in the scope of veterinary services that were being offered.*

3. *ARS § 32-2232 (11) Gross negligence for performing surgery on a brachycephalic breed without an endotracheal tube and oxygen.*

4. *ARS § 32-2232 (12) as it relates to AAC R3-11-501 (1) failure to provide current professional and scientific knowledge by performing surgery on a brachycephalic breed without an endotracheal tube and oxygen.*

5. *ARS § 32-2232 (18) as it relates to AAC R3-11-702; failure to have oxygen available for surgical procedures.*

6. *ARS § 32-2232 (18) as it relates to AAC R3-11-704 (3) failure to have an oxygen tank for animals that will receive general anesthesia.*

7. *ARS § 32-2232 (21) as it relates to AAC R3-11-502 (H) (1) failure to obtain signed authorization, a verbal authorization that is witnessed by one other individual and documented in the medical record, prior to general anesthesia or surgery is performed.*

8. *ARS § 32-2232 (21) as it relates to AAC R3-11-502 (H) (3) failure to record the animal's heart rate and respiratory rate immediately after giving a general anesthetic and monitored and recorded every 15 minutes while anesthesia is being administered.*

Following the Informal Interview with Respondent, although there were concerns, since Respondent did not, or ever intend to, receive compensation for the service provided the Board dismissed this issue with no violation in accordance with ARS § 32-2211(2).

Respectfully submitted this 21st day of March, 2018.

Arizona State Veterinary Medical Examining Board

Jim Loughead, Chair